SECTION 1915(c) WAIVER FORMAT

1. The State of Alaska requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b.__X__ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.____ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b._____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c._____ Hospital

   d.____ NF (served in hospital)

   e._____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.____ aged (age 65 and older)

   b.__X__ disabled

   c.____ aged and disabled

d.____ mentally retarded

e._____ developmentally disabled

f. ____ mentally retarded and developmentally disabled

g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. X Waiver services are limited to the following age groups (specify):

0 - 21 inclusive

b._____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c._____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs,but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. X Other criteria. (Specify):

The target population includes children who have a severe chronic physical condition and who would receive long-term care in a facility for more than 30 days per year who have a severe chronic physical condition which results in a prolonged dependency on medical care or technology to maintain health and well-being and who:

(1) experience periods of acute exacerbation or life-threatening conditions,
(2) need extraordinary supervision and observation, and
(3) need frequent or life-saving administration of specialized treatments, or dependency on mechanical support devices.

e._____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.

a.____ Yes b.__X__ No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.____ Yes b.____ No c.__X__ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.____ Yes b.__X__ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.____ Yes b.__X__ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.__X_____Case management

b._____Homemaker

c._____ Home health aide services

d._____ Personal care services

e. X Respite care

f. _____ Adult day health

g. X Habilitation

X Residential habilitation

X Day habilitation

____ Prevocational services

X Supported employment services

____ Educational services

h. X Environmental accessibility adaptations

i. _____ Skilled nursing

j. X Transportation

k. X Specialized medical equipment and supplies

l. X Chore services

m. _____ Personal Emergency Response Systems

n. _____ Companion services

o. _____ Private duty nursing

p. _____ Family training

q. _____ Attendant care

r. _____ Adult Residential Care

____ Adult foster care

____ Assisted living

s._____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services

____ Prescribed drugs

____ Other (specify):

_____

t.__X_____ Other services (specify):

1) Meals Services,
2) Intensive active treatment/therapies,

u._____ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. _____ Meals furnished as part of a program of adult day health services.

c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and
2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

    a.____ Yes b.__X__ No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2001 is requested.

20. The State contact person for this request is Jon Sherwood, MAA IV , who can be reached by telephone at (907) 465-3355 .

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____
Print Name: Karen Perdue
Title: Commissioner, Department of Health & Social Services
Date: July 24, 2001

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by the _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

__X__ The waiver will be operated by The Division of Mental Health and Development Disabilities, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. __X__ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

___X__ Other Service Definition (Specify): In Alaska, Case Management is referred to as Care Coordination.

Care coordinators assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Care Coordinators shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

Care Coordinators shall initiate and oversee the process of reviewing plans of care at such intervals as are specified in Appendices C & D of this request.

Within the context of HCB waiver services care coordination may include the following functions:

Evaluation and/or reevaluation of the need for specific waiver services, development and/or review of the plan of care, coordination of multiple services and/or providers, monitoring of quality of care, review of medical necessity of waiver services.

b._____Homemaker:

_____Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):_____

c._____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d._____Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

_____ As indicated in the plan of care

_____ Other (Specify):

4. Relationship to State plan services (Check one):

_____ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The Waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. X Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

X Other service definition (Specify):

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Voucher services for respite: Individuals providing voucher respite services mustmeet the certification standards for respite service providers in Appendix B-2.

Due to the remoteness of most Alaskan communities, the labor pool is restricted to individuals living in the immediate area. Furthermore, provider agencies are concentrated in larger towns and cities, thus making it difficult or impossible to deliver respite services in traditional manners. Therefore, offering respite care under a voucher system is an option that may be selected. Voucher services will empower families by giving them direct control over how and when the services are provided and will enable closer scrutiny of the quality of those services. Voucher respite care may be provided only if approved in the recipient's plan of care. Services under this option will be administered as follows:

1. The family will select and train an individual to render respite services.
2. The family signs a letter of agreement with the provider agency acknowledging responsibility for compliance with waiver caregiver qualifications and Internal Revenue Service laws.
3. The provider agency issues coupons to the family based on the number of hours of service at the rate approved in the plan of care and prior authorized on the MMIS. Coupons may be issued monthly or quarterly. The coupon includes a line for the family's signature stating that the respite worker meets qualifications defined in the waiver.

4. When the service is rendered, the family notifies the provider that the service was rendered satisfactorily.
5. The coupon is submitted to the provider agency for payment of services rendered.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

__X__ Individual's home or place of residence

__X__ Foster home (DFYS Licensed Foster or DMHDD Assisted Living Home)

__X__ Medicaid certified Hospital

__X__ Medicaid certified NF

_____ Medicaid certified ICF/MR

__X__ Group home (DFYS Licensed Foster or DMHDD Assisted Living Home)

__X__ Licensed respite care facility (DFYS Licensed Foster or DMHDD Assisted Living Home)

____ Other community care residential facility approved by the State that is not a private residence (Specify type):

f._____Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

_____ Other service definition (Specify):

g. X Habilitation:

X Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

X Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition,

day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at

preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

_____Individuals will not be compensated for prevocational services.

_____When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

____ Educational services, which consist of special education and services defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

__X__ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.___x___Yes 2._____No

_____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.____X____ Environmental accessibility adaptations: (Alaska regulations refer to this service as "Environmental Modifications")

____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as

carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (Specify):

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Each environmental modification must have a specific adaptive purpose that provides accessibility and safety..

i. Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

j. X Transportation:

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k. X Specialized Medical Equipment and Supplies:

X Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

____ Other service definition (Specify):

l. X Chore services:

X Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

____ Other service definition (Specify):_____

m._____ Personal Emergency Response Systems (PERS)

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

n._____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

o._____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify):

p._____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q._____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify):

_____ Other service definition (Specify):

r._____ Adult Residential Care (Check all that apply):

_____Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed__). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

_____ Home health care

_____ Physical therapy

_____ Occupational therapy

_____ Speech therapy

_____ Medication administration

_____ Intermittent skilled nursing services

_____ Transportation specified in the plan of care

_____ Periodic nursing evaluations
_____ Other (Specify):

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

_____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1) Meal Services: Hot or other appropriate meals which each meet at least one-third of the daily Recommended Dietary Allowance, served to recipients in their homes or day program sites that are necessary to prevent institutionalization. Meals shall not constitute a "full nutritional regimen".

2) Intensive Active Treatment/Therapies: The provision of treatment or therapy provided by a qualified professional which is oriented to a client-specific problem. These time-limited interventions are designed to address a family problem, or a personal, social, behavioral, mental or substance abuse disorder in order to maintain or improve effective functioning. Intensive active treatment services are determined necessary when intervention requires precision and knowledge possessed only by specific disciplines, and specially trained professionals. Services are required when an individual needs intervention to decelerate regression of behaviors. Services are also necessary when the recipient requires rapid skill development and acquisition. This service is necessary to prevent institutionalization.

t. _____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

_____ Prescribed drugs

_____ Other State plan services (Specify):

u._____ Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

_____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations
(Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART
The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Qualified individuals may become certified as a Care Coordination and/or HCB Agency.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	Other Standard
Care Coordination	DMHDD HCB Agency or DMHDD CC Agency		Certified by DMHDD under 7AAC 43.1090	
Day Habilitation	DMHDD HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Supported Employment Services	DMHDD HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Intensive Active Treatment Therapies	HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Meals	ACoA Grantee funded to provide meals or, Certified school lunch programs		DEC Certification 18 AAC31 Department of Education 42 CFR 440.180 (b)	
Chore	HCB Agency		Certified by DMHDD under 7AAC 43.1090	

	PROVIDER	LICENSE	CERTIFICATION	Other Standard
Specialized Medical Equipment and supplies	Medical Supply vendor	Alaska Business License		
Environmental Modifications	HCB Agency Licensed Contractor	Contractors licensed under 12 AAC 21.010-21.990	Certified by DMHDD under 7AAC 43.1090	
Transportation	HCB Agency	Alaska State Driver's License	Certified by DMHDD under 7AAC 43.1090	
Residential Habilitation				
Residential Habilitation provided in consumer's home	DMHDD HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Residential Habilitation provided in an out of home placement	DMHDD HCB Agency		Certified HCB Agency under 7AAC 43.1090	
Respite				
Hourly respite (including hourly voucher respite)	HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Out of home daily respite (including respite agencies and out of home voucher respite)	HCB Agency, Hospital or Nursing Facility	Licensed hospital or nursing home	Certified by DMHDD under 7AAC 43.1090	

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3
KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provide, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__X__ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. _x_ Low income families with children as described in section 1931 of the Social Security Act.

2. _x_ SSI recipients (SSI Criteria States and 1634 States).

3. ____ Aged, blind or disabled in 209(b) States who are eligible under ə 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. _x_ Optional State supplement recipients

5. ____ Optional categorically needy aged and disabled who have income at (Check one):

   a. ____ 100% of the Federal poverty level (FPL)

   b. ____% Percent of FPL which is lower than 100%.

6. _x_ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   _x_ A. Yes ___B. No

   Check one:

   a. _x_ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

   b. ____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based

services in order to remain in the community are included in this waiver: (check all that apply):

(1)___ A special income level equal to:

____ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.__x___ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

See attachments to Appendix C: Categories of Medicaid Eligibility

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 42 CFR 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 42 CFR 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and ∋435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--42 CFR435.726 and 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--'1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of ə1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The ə1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in ə1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. x **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. x The following standard included under the State plan (check one):

(1)___ SSI
(2)___ Medically needy
(3) x `The special income level for the institutionalized
(4)___ The following percent of the Federal poverty level):___%
(5)___ Other (specify): _____

B.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard
B.___ Optional State supplement standard
C.___ Medically needy income standard
D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ___% of ____standard.

F.___ The amount is determined using the following formula:
G.__x__ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard
B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.___ Other

G. __x__ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):
(1)___ SSI
(2)___ Medically needy
(3)___ The special income level for the institutionalized
(4)___The following percentage of the Federal poverty level:___%
(5)___ Other (specify):
_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under ∋435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:
B.___ The medically needy income standard_____;
C.___ The following dollar amount: $_____*
* If this amount changes, this item will be revised.
D.___ The following percentage of the following standard that is not greater than the standards above:_____% of
E.___ The following formula is used to determine the amount:
F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard
B.___ Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.
C.___ The following dollar amount:$_____*
* If this amount changes, this item will be revised.
D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.
E.___ The following formula is used to determine the amount:
F.___ Other
G. Not applicable (N/A)
H. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. x The State uses the post-eligibility rules of ∋1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under ∋1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c) x The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
___%

(e)___ The following dollar amount
$___**

**If this amount changes, this item will be revised.

(f) The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individual s maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

Children with Complex Medical Conditions		
Category	**Social Security Laws**	**Federal Regs**
TITLE IV-E Adoption and Foster Care Children	1902(a)(10)(A)(i)(I)	42 CFR 435.145
Post-Partum	1902(e)(5) and (6)	
NewBorn	1902(a)(10)(A)(i)(III) 1902(e)(4) 1903(l)(1)(B)	42 CFR 435.117
Pregnant Women	1902(e)(6) 1902(a)(10)(A)(i)(III) 1902(l)(1)(A)	42 CFR 435.116 42 CFR 435.170
Denali KidCare (poverty level children CHIP expansion)	1902(a)(10)(A)(i)(VI), (VII), (III) 1902(1)(C) and (D)	42 CFR 457.70
Transitional Medicaid	1902(a)(10)(ii)(XIV)	42 CFR 435.112
4-month Post Medicaid	1902(a)(10)(A)(i)(I) 1931	42 CFR 435.115(f)
Individuals eligible for AFDC except for 1972 20% increase in OASDI payments	None	42 CFR 435.114
Individuals eligible for Medicaid in 1973	None	42 CFR 435.131 42 CFR 435.132 42 CFR 435.133
Individuals eligible for SSI/APA except for 1972 20% increase in OASDI payments	1634(C)	42 CFR 435.134
Children who were receiving SSI on August 22, 1996 and lost SSI because of the change in the definition of disability for children	1634(e)	
Individuals eligible for AFDC or SSI if not in a medical institution	1902(a)(10)(ii)(IV)	42 CFR 435.211
Retroactive Medicaid	1902(a)(34) 1905(a)	
Breast & Cervical Cancer	1902(a)	
Under 21	1902(a)(10)(A)(ii) 1905(a)(i)	42 CFR 435.222
State Only adoption assistance	1902(a)(10)(A)(ii)(VIII)	42 CFR 435.227
Working Disabled Medicaid Buy-In	1902(a)(10)(A)(ii)(XIII) 1905(s)	None
Disabled Children at Home (TEFRA)	1902(e)(3) 1915(c)(10)	42 CFR Part 435 Subpart G and F
Disabled Widow(er)s	1634(b)	42 CFR 435.137 42 CFR 435.138
SSI "Disabled Adult Children"	1634(c)	42 CFR 435.122
Ineligible for SSI or APA because of Requirements prohibited by Medicaid	None	42 CRF 435.122
QDWI	1902(a)(10)(E)(ii) 1905(s)	

APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

__X__ Other (Specify):

Licensed Registered Nurse who works for Division of Senior Services

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

_____ Every 3 months

_____ Every 6 months

__X__ Every 12 months

_____ Other (Specify): _____

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

__X__ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

_____ Physician (M.D. or D.O.)
_____ Registered Nurse, licensed in the State
_____ Licensed Social Worker
_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
_____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

__X__ "Tickler" file

__X__ Edits in computer system

__X__ Component part of case management

_____ Other (Specify)

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid agency in its central office

___ By the Medicaid agency in district/local offices

__X__ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

__X__ By the case managers

__X__ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

___ By service providers

___ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

__X__ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ALASKA LONG TERM CARE ASSESSMENT

Instructions

The Alaska Long Term Care Assessment (ALTCA) must be completed by a Medicaid Waiver Care Coordination provider. The assessment is required for all persons seeking Medicaid home and community-based waiver services from the Division of Senior Services.

SECTION I (pages 1-4): Comprehensive Assessment for HCB Waiver Level of Care Eligibility

SECTION II (pages 5-13): Comprehensive Assessment for HCB Waiver Plan of Care

Both sections must be completed for all new applicants seeking placement on a HCB Waiver Program for persons eligible for the level of care provided in a nursing facility:

- Older Alaskans 65+ years of age
- Adults with Physical Disabilities 21-64 years of age
- Children with Complex Medical Conditions age 0-21 years of age

Level of Care is authorized for 365 days. Level of Care should be renewed prior to the anniversary date. Submit the following documents for clients due for annual Waiver Level of Care Reauthorization:

- Section I: pages 1-4 with new medical certification and care coordinator signatures
- Section II: Submit all pages.

The documents required for each long-term care program are indicated below. Refer to the Medicaid Waiver Desktop Manual for additional information.

LONG TERM CARE PROGRAM	SECTIONS REQUIRED TO BE COMPLETED
HCB Waiver Program for Older Alaskans	Medicaid Long Term Care Referral Screening Guide, Proof of DPA Application, ALTCA (pages 1-13). Upon LOC approval from DSS, submit plan of care and cost sheet.
HCB Waiver Program for Adults with Physical Disabilities	Medicaid Long Term Care Referral Screening Guide, Proof of DPA Application, ALTCA (pages 1-13). Upon LOC approval from DSS, submit plan of care and cost sheet.
HCB Waiver Program for Children with Complex Medical Conditions	Medicaid Long Term Care Referral Screening Guide, Proof of DPA Application, ALTCA (pages 1-13). Upon LOC approval from DSS, submit plan of care and cost sheet.

SECTION I (pages 1-4): Comprehensive Assessment for HCB Waiver Level of Care Eligibility

Date of Screen: _____ **PERMANENT CLIENT INFORMATION**

Name:_____ Mail
Address:_____ (last) (first) (middle initial)
City:_____State:_____Zip:_____Phone:_____

Date of Birth:_____ Age:_____ Social Security #:_____ Medicaid #_____

Medicare #:_____Veteran #:_____ Other Insurance #_____

[ ] Same as above **PRESENT LOCATION**
Facility:_____Street:_____
____

City:_____State:_____Zip:_____Phone:_____
_____

DEMOGRAPHIC DATA (circle appropriate information)

RACE	**SEX**	**MARITAL STATUS**	**EDUCATION**	**#____ TOTAL IN HOME**	**LIVING ARRANGEMENT**
White	Female	Married	Less than third	_____ Lives Alone	Owns Home
Alaska Native	Male	Widowed	3rd through 8th	_____ Spouse	Rents Home/Apt
American Indian		Divorced	Some High Schl	____ Child(ren)	Foster Home
Black	**PRIMARY**	Separated	H.S. Graduate	_____ Parent(s)	Residential Facility
Hispanic	**LANGUAGE**	Single	Some College	_____ Other Relative(s)	Pioneers' Home
Asian/Pac.Is.	_____		College Graduate	_____ Non-Relative(s)	Nursing Facility
Other_____			Other	_____ Other	Other_____

REASON FOR REFERRAL

HCB Waiver Program for:
[ ] Older Alaskans
[ ] Adults with Physical Disabilities

Is this an Adult Protective Services Case? [ ] Yes [ ] No [ ] Unknown

[ ] Other:_____

PRESENTING PROBLEMS

This section may be more than one page in length; it may also be attached as additional pages.

I. Problem List:
(The assessor should list the client's present problems in this section. Include the client's Medical diagnoses and Nursing diagnoses, self care deficits, and number of falls here. Include dates of significant illnesses and injuries.)

II. Current Condition:
(Type a brief 1 paragraph narrative describing clients current status/condition here)

III. Nursing Needs:
(Type list of client's specific needs for nursing care here, which will qualify them for waiver eligibility. Specify whether each need requires *assessment*, *monitoring*, or *provision* of nursing care. Needs identified here serve as the basis for the waiver plan of care.)

_____
Care Coordinator Signature **Date**

Care Coordination Agency:
_____

TREATMENT/THERAPIES/NURSING SERVICES: Indicate whether client currently receives (R) or needs (N), frequency of service (e.g., if 2 or 3 x/wk, list this under the weekly column), who provides (if provided), and any comments.

SERVICES	Receives or Needs (R or N)	Frequency of Service daily	weekly	monthly	PROVIDER	COMMENTS
Ambulation						
Bandage/Dressing Changes						
Bladder Program/Urinary Incontinence						[ ] Frequent [ ] Intermittent
Bowel Program						[ ] Incontinence [ ] Constipation
Catheter Care						
Chemotherapy						
Feeding: Tube						
Feeding: Parenteral/IV						
Feeding: Syringe						
Injections						
Medications/Monitoring						
Occupational Therapy						
Oxygen (specify liters/minute)						[ ] continuous [ ] as needed
Ostomy Care						
Physical Therapy						
Radiation						
Range of Motion						
Respiratory Therapy						
Skin Care						
Speech Therapy						
Wound Care						
Other:_____						
_____						
_____						

Additional Nursing or Care Needs:

MEDICATIONS: List all prescription and over the counter drugs being used by the client, the dose, frequency, how they are taken (route), length of time used (duration), who helps the client use the medication, and verification by the physician that the medication is currently prescribed. Use the following codes to record the information. Additional pages may be attached as needed.

Frequency Code:

01 = (QD) daily	04 = (QID) 4 x daily	07 = (QOD) every other day	10 = Other (describe)
02 = (BID) 2 x daily	05 = (Q) 5 or more daily	08 = (HS) at bedtime	88 = (NA) Not Applicable
03 = (TID) 3 x daily	06 = (PRN) as needed	09 = Weekly	99 = Don't Know/No Response

Route Code:

01 = Oral	03 = Injection	05 = Inhalant	88 = (NA) Not Applicable
02 = Topical (skin)	04 = Rectal/Vaginal	06 = Other (describe)	99 = Don't Know/No Response

Who Code:

01 = Self	04 = RN or LPN	06 = Other Agency	88 = (NA) Not Applicable
02 = Caregiver	05 = Home Health Aide	07 = Other (describe)	99 = Don't Know/No Response

NAME OF MEDICATION	Dosage	Frequency	Route	Who	Length of Use	Physician Verification	COMMENTS
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

FACTORS THAT MAY AFFECT INSTITUTIONALIZATION (check all that apply)

(The more factors checked the more at risk of institutionalization)

[ ] Has moderate to total needs for assistance with personal care
[ ] Is 75 years of age or older
Is incontinent of [ ]bowel [ ] bladder
[ ] Lives alone
[ ] Needs assistance with multiple prescribed medications not for sale over the counter
[ ] Is without adequate family or other social support

Last Physician Visit:
[ ] Within last month
[ ] 1-6 months
[ ] 7 months to 1 year
[ ] Over 1 year
Reason:
[ ] Routine/Annual
[ ] Treatment (Condition:_____)
[ ] New Problem:_____

Hospital Admission in Last Year:
_____ # of Admissions _____ # of Days
Reason:
[ ] Illness
[ ] Accident
[ ] Surgery
[ ] Diagnostic/Evaluation
[ ] Treatment/Therapy
[ ] Other_____

Nursing Home Admission in Last Year:
_____ # of Admissions _____ # of Days
Reason:
[ ] Illness
[ ] Recovery/Therapy
[ ] Respite
[ ]Other _____

At present client is [ ] low [ ] moderate [ ] high risk for admission to a Nursing Facility .

[ ] Diverted from impending NF admission? [ ] Deinstitutionalized (removed) from NF? [ ] Other: (provide details below)

Additional information:

_____

MEDICAL CERTIFICATION

for determining NF eligibility for HCB Waiver Programs

(Note: Physician, Advanced Nurse Practitioner or Physician Assistant signing here, please include name/address under physician information section on next page)

Primary Diagnosis:_____

Secondary
Diagnosis:_____

COMMENTS:_____

_____

_____

To the best of my knowledge the above information is true, accurate, and complete and the requested services are medically necessary.

Provider
Signature:_____Date:_____ID#:_____

Printed Provider Name: _____

CARE COORDINATOR (to be completed by care coordinator completing assessment)

Assessor
Signature:_____Date:_____Phone:_____FAX:_____

Agency Name:
_____

Supervisor Approval (if required):_____ Date: _____Phone: _____FAX:_____

DIVISION OF SENIOR SERVICES APPROVAL

HCB Waiver Program Level of Care

[ ] Approved Nursing Facility Level of care

[ ] Deferred NF LOC Date:_____
Reason:_____

[ ] Denied NF LOC
Reason:_____

Period Approved: (one year from approval date unless specified otherwise)_____

COMMENTS:_____
_____

_____

Signature:_____Date:_____

PERSONAL CONTACTS

LEGAL REPRESENTATIVE(S): [ ]Self or:
Name:_____Relation_____Address:_____

City:_____ State: _____Zip:_____Work PH:_____Home PH _____
[ ] Parent [ ] Power of Attorney (POA) [ ] Durable POA [ ] Legal Guardian [ ] Conservator Assisted with assessment? [ ] yes [ ] no

Name:_____Relation_____Address:_____
City:_____ State:_____Zip:_____Work PH:_____Home PH_____
[ ] Parent [ ] Power of Attorney (POA) [ ] Durable POA [ ] Legal Guardian [ ] Conservator Assisted with assessment? [ ] yes [ ] no

CAREGIVER(S):
Primary:_____Relation_____Address:_____
City:_____ State:_____Zip:_____Work PH:_____Home PH _____
Assisted with assessment? [ ] yes [ ] no

Secondary:_____Relation_____Address:_____

City:_____ State:_____Zip:_____Work PH:_____Home PH:_____
Assisted with assessment? [ ] yes [ ] no

EMERGENCY CONTACT(S):
Name:_____Relation_____Address:_____

City:_____ State:_____Zip:_____Work PH:_____Home
PH:_____ Assisted with assessment? [ ] yes [ ] no

Name:_____Relation_____Address:_____

City:_____ State:_____Zip:_____Work PH:_____Home
PH:_____ Assisted with assessment? [ ] yes [ ] no

ADVANCED DIRECTIVES

Does client have living will? [ ] yes [ ] no Durable power of attorney? [ ] yes [ ] no If not, have they been informed? [ ] yes [ ] no

SUMMARY OF CURRENT/PAST COMMUNITY PROVIDERS (optional section)

NAME:	ADDRESS:	PHONE:	PROVIDER STATUS	CLIENT SATISFACTION
			[ ] Current [ ]Past	[ ] Good [ ] Fair [ ] Poor
			[ ] Current [ ]Past	[ ] Good [ ] Fair [ ] Poor
			[ ] Current [ ]Past	[ ] Good [ ] Fair [ ] Poor
			[ ] Current [ ]Past	[ ] Good [ ] Fair [ ] Poor
			[ ] Current [ ]Past	[ ] Good [ ] Fair [ ] Poor

PHYSICIAN/MEDICAL PROVIDER INFORMATION (list primary provider first)

NAME:	ADDRESS:	CITY/STATE/ZIP:	PHONE:

HEALTH CONDITION: Indicate whether the client, caregiver and/or physician perceive the following conditions as problems or limiting to the client. Complete as possible or necessary for each reporter (client, caregiver, physician). Indicate whether the client is being treated for the conditions listed. Under comments, indicate age of diagnosis for asterisked (*) conditions.

HEALTH CONDITION	Client		Caregiver		Physician		Treatment		COMMENTS
	no	yes	no	yes	no	yes	no	yes	
HEART/CIRCULATION: Circulatory Problems									
Congestive Heart Failure 428.0									
Heart Attack/Heart Disease									
High Blood Pressure 401.9									
Other: specify_____									
RESPIRATORY: Asthma 493.9									
Bronchitis									
Emphysema 492.8									
Pneumonia 486									
Tuberculosis									
Other: specify_____									
NEUROLOGICAL: Alzheimer's Disease 330									
Autism *									
Cerebral Palsy 343.9 *									
Epilepsy/Seizure Disorder 780.3 *									
Head Injury *									
Mental Retardation *									
Multiple Sclerosis *									
Muscular Dystrophy *									
Spina Bifida *									
Spinal Cord Injury 952.9 *									
Stroke									
Other: specify_____									
SENSORY IMPAIRMENT: * Hearing									
Vision: [ ] glaucoma [ ] cataracts									
Other: specify_____									
OTHER: Arthritis 716.9									
Bladder/Kidney/Urinary Tract Problem									
Cancer 199.1									
Communication/Speech Disorder *									
Dental									

Diabetes 250									
Drug/Alcohol									
Fractures									
HIV/AIDS									
Incontinent: bladder									
Incontinent: bowel									
Intestinal/Stomach/Bowel Problem									
Mental Illness									
Osteoporosis 733									
Pain									
Sexual Problem									
Sleep Problem									
Other: specify_____									
_____ _									
Allergies: _____									

GENERAL COMMENTS:

NUTRITION & DIET: Indicate eating problems/cause and special dietary needs.

EATING PROBLEM	no	yes	COMMENTS	DIETARY NEEDS	no	yes	COMMENTS
Chewing				Pureed food			
Lack/poor fitting dentures				No added salt			
Difficulty swallowing				Low salt			
Lack of appetite				Diabetic diet			
Food allergies				Low fat/cholesterol			
Lack of money for food				Dietary supplements			
Other:_____				Other:_____			

Current Wt: Height: Meals eaten daily? [ ] 1 or less [ ] 2 [ ] 3 [ ] more than 3

Recent Weight Loss? (how much/over time?)

GENERAL COMMENTS:

COGNITIVE/BEHAVIORAL: Indicate client's cognitive/behavioral status by completing section below.

MEMORY: (Ability to recall what was learned/known) Short Term (ability to recall after 5 minutes): [ ] memory OK [ ] memory problem Onset of Difficulty: [ ] 1-6 months [ ] 6 mos.-1 year [ ] over 1 yr. [ ] Unknown Long Term (ability to recall past): [ ] memory OK [ ] memory problem Onset of Difficulty: [ ] 1-6 months [ ] 6 mos.-1 year [ ] over 1 yr. [ ] Unknown	COMMENTS:
DAILY DECISION MAKING SKILLS (able to make decisions about day to day activities): [ ] Functions independently [ ] Problems in new situations only [ ] Requires cues and/or supervision [ ] Unable to make decisions	COMMENTS:

Rate the following cognitive/behavior patterns according to the following codes by placing a 'X' in the appropriate column:

Unable to assess Not a problem Occasional Problem (1-2 times monthly) Frequent Problem (several times weekly) Daily Problem

PATTERN	Unable to Assess	Not a Prob.	Occ.	Freq.	Daily	COMMENTS:
ORIENTATION: Recognizes family members/caregivers						
Orientation in home, able to find bedroom/bathroom, etc. without assistance						
Completes routine activities without confusion						
BEHAVIOR: WANDERING (moves with no rational purpose, seemingly oblivious to needs/safety)						
VERBALLY ABUSIVE (threaten, screams, curses at others)						
PHYSICALLY ABUSIVE (hits, shoves, scratches, sexually abusive to others)						
SOCIALLY INAPPROPRIATE/DISRUPTIVE (makes disruptive sounds, self-abusive acts, sexual behavior/disrobing in public, smeared food/feces, etc.)						
MOOD: VERBAL EXPRESSIONS OF DISTRESS (vocal expressions of sadness, sense that nothing matters, hopelessness, worthlessness, anxiety or grief)						
OBSERVABLE SIGNS OF MENTAL DISTRESS Tearfulness, emotional, groaning, sighing, breathlessness						
Motor agitation such as pacing, handwringing or picking						
Failure to eat or take medications, withdrawal form selfcare or leisure activities						
Persistent concern with health						
Recurrent thoughts of death (e.g., believes s/he is about to die)						
Suicidal/homicidal thoughts/actions						
Other (describe:_____)						

FUNCTIONAL INFORMATION: Indicate the level at which the client is able to perform the listed activities by circling the level of performance. Indicate the source(s) and frequency of help. Under comments briefly describe how client manages the activity or the help required including the type of assistive devices currently used. Use the following codes to record the information.

Level of Performance Code:
0 = Independent
1 = Assistive device/mechanical assistance only
2 = Supervision and non-physical human assistance (oversight/verbal cues)
3 = Supervision and minimal physical assistance
4 = Substantial human physical assistance
5 = Maximum physical assistance (total dependence)

Source of Help Code:
0 = None 2 = Children 4 = Other relatives 6 = Private paid help 8 = Other
1 = Spouse 3 = Parent(s) 5 = Friend/volunteer 7 = Publicly funded help

Frequency of Help Code:
0 = Not provided 2 = 2-3 times/week 3 = 4-6 times/week 4 = daily 5 = several times per day
1 = once/week or less

ACTIVITIES OF DAILY LIVING	Performance Level	Source(s)	Frequency	COMMENTS
EATING/DRINKING (Get food/liquids into the body)	0 1 2 3 4 5		0 1 2 3 4 5	
TOILETING (Get to/from toilet room, transfer on/off toilet, manage clothes, clean/flush)	0 1 2 3 4 5		0 1 2 3 4 5	
BATHING (Get to/from tub, fill tub/turn on shower, wash/towel dry)	0 1 2 3 4 5		0 1 2 3 4 5	
TRANSFERS (Get in/out of bed/chair/car, etc.)	0 1 2 3 4 5		0 1 2 3 4 5	
DRESSING (Get clothes, put them on, fasten/take off)	0 1 2 3 4 5		0 1 2 3 4 5	
GROOMING (Comb/brush/care for hair, shave, brush teeth/clean dentures)	0 1 2 3 4 5		0 1 2 3 4 5	
INSTRUMENTAL ACTIVITIES OF DAILY LIVING				
MEAL PREPARATION (Plan, prepare, cook, and serve food)	0 1 2 3 4 5		0 1 2 3 4 5	
SHOPPING (Get to/from store, select/pay/get food home/put away)	0 1 2 3 4 5		0 1 2 3 4 5	
MEDICATIONS (Take appropriate dosage at correct times as directed)	0 1 2 3 4 5		0 1 2 3 4 5	
HOUSEKEEPING (Dust, wash dishes, make beds, vacuum/sweep/clean floors)	0 1 2 3 4 5		0 1 2 3 4 5	
LAUNDRY (Put clothes in/out washer/dryer, hand wash/dry, fold/put away)	0 1 2 3 4 5		0 1 2 3 4 5	
COMMUNICATION (Communicate needs/respond to others)	0 1 2 3 4 5		0 1 2 3 4 5	
TASK PLANNING (Plan/carry out routine activities, such as dressing/bathing etc.)	0 1 2 3 4 5		0 1 2 3 4 5	
MONEY MANAGEMENT (Pay bills, write checks, handle cash, make change)	0 1 2 3 4 5		0 1 2 3 4 5	
TELEPHONE (Look up numbers, dial/answer phone)	0 1 2 3 4 5		0 1 2 3 4 5	
TRANSPORTATION (Arrange/use any transportation)	0 1 2 3 4 5		0 1 2 3 4 5	
MOBILITY				
MOBILITY INDOORS (Move around inside home)	0 1 2 3 4 5		0 1 2 3 4 5	
MOBILITY OUTDOORS (Move around outside, within walking distance of home)	0 1 2 3 4 5		0 1 2 3 4 5	
CLIMB STAIRS (Go up/down flight of stairs, negotiate other steps)	0 1 2 3 4 5		0 1 2 3 4 5	

ASSISTIVE DEVICES: Indicate availability and need of all assistive devices by placing an 'X' in the appropriate column (has & uses) or (needs & doesn't have). If has and doesn't use, indicate under comments.

DEVICE	Has & Uses	Needs & Doesn't Have	COMMENTS:	DEVICE	Has & Uses	Needs & Doesn't Have	COMMENTS:
MOBILITY: Self propelled wheelchair				**SKIN CARE:** Special mattress pad			
Battery propelled wheelchair				Special mattress			
Ramp				Gel pad/second skin			
Walker/Cane				Body protectors			
Prothesis				Whirlpool			
Backbrace				**COMMUNICATION:** Hearing aid			
Crutches				TDD, teletype			
Support dog				Interpreter, sign			
Transfer board				Interpreter, language			
Lift				Lifeline			
EATING: Dentures/partial plate				Voice box			
Hand splint/brace				Symbol board			
Special utensils/plate				Communication board			
Gastronomy tube				Picture book			
TOILETING: Raised toilet seat				**MISCELLANEOUS:** Oxygen concentrator			
Incontinence pads				Ventilator			
Bed pan/urinal				Pacemaker			
Portable commode				Prosthesis			
Grab bars				Hospital bed			
Catheter				Other specialty lifts			
Ostomy equipment				Other:_____			
BATHING: Bath bench				**VISION:** Glasses or contacts			
Grab bar/tub rail				Lens			
Hand-held shower				Talking book			
Shower chair				Braille			
				Magnifying lens			

COMMUNICATION: Indicate client's communication abilities by circling appropriate response below.

VISION: (Ability to see in normal light with glasses/contacts if used)
- Good - sees regular print in newspapers/books
- Fair - sees headlines but not regular print in newspapers
- Poor - cannot headlines
- Blind - no functional vision

COMMENTS:

MAKING SELF UNDERSTOOD: (Ability to express self, however able)
- Understood
- Usually Understood - has difficulty finding words/finishing thoughts
- Sometimes Understood - ability is limited to making concrete requests
- Never/Rarely Understood

COMMENTS:

HEARING: (Ability to hear with hearing aid if used)
- Good - hears normal conversation, TV, phone
- Fair - some problems hearing when not in a quiet setting
- Poor - hear only if volume is turned up or speaker raises voice
- Deaf - no functional hearing

COMMENTS:

ABILITY TO UNDERSTAND OTHERS: (Ability to understand verbal information - however able)
- Understands
- Usually Understands - may miss some part/intent of message
- Sometimes Understands - responds adequately to simple direct communication
- Never/Rarely Understands

COMMENTS:

PHYSICAL ENVIRONMENT: Does the client's physical environment present obstacles that should/could be changed or eliminated to promote his/her independence and/or functional capacity? Assessor should ask if there are any obstacles/problems and not give examples from the list below. Indicate whether the problem can be remedied by the following code:

NA = Item/condition does not exist Minor = Minor repair (under $500 and/or friends/family can fix)
Major = Major repair (over $500 and/or professional must fix)

CONDITION	Problem		Repair Needed			DESCRIPTION
	no	yes	NA	minor	major	
Safe access to all necessary areas						
Security (locks on windows/doors)						
Adequate bathing facilities						
Adequate toilet facilities						
Adequate running water						
Adequate electricity						
Adequate heating						
Working appliances						
Access to laundry facilities						
Access to telephone						
Condition of stairs						
Adequate sanitation (trash removal, etc.)						
Adequate outdoor maintenance (snow shoveling, etc.)						
Safety of neighborhood						
Adequate pet care						

VOLUNTARY SUPPORT SYSTEM: The person the client relies on the most for help in caring for themself should be listed as the primary caregiver on the first page of assessment as well as the name of the person who also helps them on a regular basis (secondary caregiver). In addition, the source of help (spouse, child, etc.) for day to day activities should be identified in the functional information section. This section is intended to gain further information regarding the client's voluntary support system.

CLIENT:
Does your primary caregiver live with you? [ ] yes [ ] no

If yes, what is their condition? [ ] cares for self [ ] requires some care in home [ ] requires total care in home

How is caregiving working? [ ] Very good [ ] Good [ ] Fair [ ]Poor

Who else may be able to help you care for yourself?

Name:_____Relation_____Address:_____

City:_____ State:_____Zip:_____Work PH:_____Home PH:_____

Name:_____Relation_____Address:_____

City:_____ State:_____Zip:_____Work PH:_____Home PH:_____

ASSESSOR:
In your judgment, how well does existing caregiver(s) meet needs of client? [ ] Excellent [ ] Adequate [ ] Inadequate

In your judgment, do you expect caregiver(s) ability to meet the client's need to:?
[ ] Increase [ ] Remain the same [ ] Decrease slightly [ ] Decrease substantially

In your judgment, what is overall stress level for existing caregiver(s) in meeting client's needs?
[ ] Low [ ] Moderate [ ] High
COMMENTS:_____

SERVICES: Indicate whether the client currently receives services by formal or informal providers, whether the unmet need for care can be provided by formal or informal (family, friends, other caregivers) providers, or whether the unmet need for care could be met by formal or informal providers, but is not available.

SERVICE	Currently Receives		Unmet Need Can Be Met By:		Unmet Need Could Be Met By, But Is Not Available:		COMMENTS
	formal	informal	formal	informal	formal	informal	
Acute Hospital							
Adult Day Care							
Adult Foster Home							
Adult Residential Care							
Care Coordination							
Chore							
Counseling							
Energy Assistance							
Environmental Modifications							
Errand Service							
Escort to Medical							
Escort to Other							
Financial Budget Assistance							
Friendly Visitor							
Guardianship/Conservatorship							
Habilitation							
Home Health Nurse							
Home Maintenance							
Hospice							
ICF/MR							
Laundry							
Legal services							
Meals							
Medical Care							
Nursing Facility							
Occupational Therapy							
Ombudsman							
Personal Care							
Physical Therapy							
Private Duty Nursing							
Protective Services							
Recreation/Socialization							
Residential/DD							
Respite Services							
Shopping Service							
Specialized Medical Equipment/Supplies							
Speech Therapy							
Telephone Reassurance							
Transportation to Medical							
Transportation to Other							
Weatherization							
Vocational Rehabilitation							

ASSESSMENT SUMMARY COMMENTS:

[ ] Children with Complex Medical Conditions Waiver

The Assessment Summary consists of three paragraphs and focuses on the psycho-social aspects of the client. This section may be more that one page long.

(1st paragraph: briefly review client's history)

(2nd paragraph: Briefly summarize client's current condition and problems.)

(3rd paragraph: State expected benefits for client's participation in the waiver program.)

Care Coordinator Signature Date

To be eligibile for the CCMC waiver, all applicants must meet all of the following targeting requirements:

____0-21 years of age and has a severe chronic condition which results in the following medical care or technology to maintain health and well being:
____ experiences periods of acute exacerbation of life-threatening conditions, and
____ needs extraordinary supervision and observation, and
____ needs frequent or life-saving administration of specialized treatments of dependency on mechanical support devices, and
____and meets NF LOC with a score of 40 or higher from the matrix below.

Alaska Nursing Facility Level of Care Scoring Standards Long Term Care and Waivers.

Category	Minimum nursing facility LOC Eligibility Threshold is 40 Points.				
1. Skilled Care Needs including but not limited to Home Health Agency or private duty nursing Services in a community setting.	None. 0 Points	Short-term, intermittent visits for the purposing of monitoring, observation and/or teaching. 5 Points	One skilled care need provided on an ongoing or regular basis for a stable long-term condition – ostomy care, phlebotomy, tracheostomy care, etc. 10 Points	One or more skilled care needs for the purpose of maintaining or improving client's current condition – uncontrolled diabetes, recent stroke, wound care requiring sterile dressing changes. 15 Points	Unstable clients with frequent care needs – ventilator dependant, intravenous therapies, hyperalimentation, gastrostomy, J-tube feedings, active rehabilitation. 20 Points
2. Medication Administration	Independent. 0 Points	Requires Reminders. 5 Points	Requires standby assistance and cueing. 10 Points	Requires physical assistance. 15 Points	Fully dependent. 20 Points
3. Stability of health condition	Admitted to hospital or NF in past 12 months. 2 Points.	Admitted to hospital or NF in past 9 months. 4 Points	Admitted to hospital or NF in past 6 months. 6 Points	Admitted to hospital or NF in past 3 months. 8 Points	Currently in Acute of Long Term Care. 10 Points
4. Management and/or intensity of treatment required for illness or Disability.	Managed by client accessing outpatient therapies. 2 Points	In-home services 3 or more days per week. 4 Points	In-home services 5 or more days per week. 6 Points	Managed by home health skilled care, personal care, etc. 7 days per week. 8 Points	Inpatient care. 10 Points
5. Cognitive Impairment Diagnosis.	Functionally independent. 1 Point	Mild STM loss, occasional confusion. 2 Points	Moderate STM loss, Questionable judgement, non-compliance. 3 Points	Advanced short term memory loss, Poor judgement, combativeness. 4 Points	24-hour supervision related to cognitive impairment or dementia. 5 Points

ADL Scores	Independent	Assistive Device	Oversight & Cueing	Supervision & Minimal assistance	Substantial Assistance	Maximum Assistance
Eating and Drinking	Independent. 0 Points	Requires use of specialized plate, glass, utensils, etc. 1 Point	Requires cues to chew/swallow, locate utensils & food. 2 Points	Requires constant supervision to ensure adequate intake, occasional assistance with feeding by caregiver to complete task correctly/safely. 3 Points	Requires frequent physical assistance by caregivers ensure adequate nutritional intake correctly/safely. 4 Points	Completely dependent on caregivers for performance of eating and drinking tasks. 5 Points
Toileting	Independent. 0 Points	Requires use of Grab bars, raised toilet seat, etc. 1 Point	Requires cues to sit, stand, void, perform Personal hygiene. 2 Points	Requires constant supervision to ensure safe, hygienic toileting, occasional assistance by caregiver with hygiene to complete task correctly/safely. 3 Points	Requires frequent physical assistance by caregivers to toilet hygienically and safely. 4 Points	Completely dependent on caregivers for performance of toileting tasks. 5 Points
Bathing	Independent. 0 Points	Requires use of grab bars, shower chair. 1 Point	Requires cues to sit, stand, wash, rinse, and dry. 2 Points	Requires constant supervision to ensure safe, hygienic bathing and occasional assistance with washing by caregiver to complete task correctly/safely. 3 Points	Requires frequent physical assistance by caregivers to bathe correctly/safely. 4 Points	Completely dependent on caregivers for performance of bathing tasks. 5 Points

ADL Scores	Independent	Assistive Device	Oversight & Cueing	Supervision & Minimal assistance	Substantial Assistance	Maximum Assistance
Mobility	Independent 0 Points	Assistive device, Mechanical assistance only – cane, walker, etc. 1 Point	Supervision and non-physical human assist – verbal cues. 2 Points	Supervision and minimal physical assistance & standby assist – gait belt, aid with balance, guidance. 3 Points	Substantial human physical assistance – one or two person assist required. 4 Points	Maximum physical assistance, total dependence, immobile. 5 Points
Transfers	Independent. 0 Points	Requires use of walker, grab bars, etc. 1 Point	Requires cues to sit, stand, ambulate, grasp, and locate objects. 2 Points	Requires constant supervision to ensure safe transfers, and occasional assistance with direction, balance, and foot placement by caregiver to complete task correctly/safely. 3 Points	Requires frequent physical assistance by caregivers to transfer correctly/safely. 4 Points	Completely dependent on caregivers for performance of transfers. 5 Points
Dressing	Independent. 0 Points	Requires use of reacher, Velcro closures, etc. 1 Point	Requires cues to select clothing, place limbs in clothing, secure fasteners. 2 Points	Requires constant supervision to ensure appropriate dressing for weather and social events, and occasional assistance with manipulating limbs and clothing by caregiver to complete task correctly/safely. 3 Points	Requires frequent physical assistance by caregivers to dress correctly/safely. 4 Points	Completely dependent on caregivers for performance of dressing tasks. 5 Points
Grooming	Independent. 0 Points	Requires use of specialized hairbrush, tooth brush, etc. 1 Point	Needs cues to sit, stand, locate grasp, and manipulate objects - combs, brushes, razors. 2 Points	Requires constant supervision to ensure appropriate grooming and occasional assistance to complete task correctly/safely. 3 Points	Requires frequent physical assistance by caregivers to complete grooming activity correctly/safely. 4 Points	Completely dependent on caregivers for performance of grooming tasks. 5 Points

Home and Community Based Services Waiver
DIVISION OF MEDICAL ASSISTANCE
4433 BUSINESS PARK BLVD.
BUILDING M
ANCHORAGE, AK 99503

CCMC
LONG TERM CARE AUTHORIZATION

CONTROL NO. _____

SECTION I - TO BE COMPLETED BY THE RECEIVING FACILITY

1. TYPE OF REQUEST
_____ INITIAL
_____ REAUTHORIZATION
_____ TRANSFER
_____ LEVEL OF CARE CHANGE
_____ RETROACTIVE REQUEST

2. RECIPIENT NAME: _____ (LAST) (FIRST) (MI)

3. RECIPIENT ID NO.: _____ 4. SEX: _____ M _____ F

5. BIRTHDATE: _____ 6. AGE: _____

7. RECIPIENT PRESENTLY AT: _____ HOME _____ ACUTE CARE _____ OTHER (SPECIFY) _____

REQUESTING PLACEMENT AT:

8. NAME OF FACILITY: **CCMC WAIVER** 9. FACILITY ID#: _____

10. DATE OF ADMISSION: _____ 11. PERIOD OF CARE REQUESTED: _____ TO _____
(PLANNED OR ACTUAL)

12. RECOMMENDED LEVEL OF CARE: _____ SNF _____ ICF _____ SWING _____ AW DAYS _____ ICF/MR

13. FACILITY U.R. COMMITTEE SIGNATURE: _____ DATE: _____

SECTION II - TO BE COMPLETED BY ATTENDING PHYSICIAN

14. PRIMARY DIAGNOSIS: _____ 15. CODE [redacted]
16. SECONDARY DIAGNOSIS: _____ 17. CODE [redacted]
_____ CODE [redacted]

18. MEDICATIONS
_____
_____
_____
_____

19. PHYSICIAN RECOMMENDED LEVEL OF CARE:
[redacted] SNF [redacted] ICF [redacted] SWING [redacted] AWD [redacted] ICF/MR

20. PERIOD OF CARE REQUESTED
[redacted] TO [redacted]

21. PHYSICIAN NAME: _____ 22. ID #: _____

ADDRESS: _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

23. PHYSICIAN SIGNATURE: _____ 24. DATE: _____

SECTION III - TO BE COMPLETED BY DMA (DIVISION OF MEDICAL ASSISTANCE)

25. DATE RECEIVED IN DMA: _____ 26. ACTION TAKEN:
___ APPROVED AS REQUESTED
___ APPROVED AS MODIFIED
___ DEFERRED _____ DATE
___ DENIED

27. APPROVED LEVEL OF CARE: ___ SNF ___ ICF ___ SWING ___ AWD ___ ICF/MR

28. PERIOD APPROVED FOR: _____ TO _____

29. COMMENTS:

30. SIGNATURE: _____ 31. DATE: _____

NOTE - AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY
BE SURE THE IDENTIFICATION IS CURRENT BEFORE RENDERING SERVICE.

32. RECIPIENT'S NAME: _____ Phone # _____

SECTION IV - SNF & ICF (COMPLETE PART A ON ALL INITIAL REQUESTS. COMPLETE BOTH PART A & B ON REAUTHORIZATION REQUESTS.)

PART A

33. CURRENT NURSING NEEDS: (SERVICES RECIPIENT REQUIRES THAT CAN ONLY BE PROVIDED BY LICENSED NURSING PERSONNEL.)

34. REHABILITATION GOALS: ____ MAINTENANCE ____ ACTIVE REHAB. IF ACTIVE REHAB: STATE GOALS, PROGRESS AND PROJECTED TIME FRAME

35. DISHARGE PLAN: _____ YES _____ NO IF YES, STATE PLAN WITH TIME FRAME. IF NO, INDICATE WHY NOT.

PART B

36. MAJOR MEDICAL PROBLEMS SINCE LAST REVIEW:

37. NUMBER OF HOSPITALIZATIONS SINCE LAST REVIEW: _____ REASONS:

38. NUMBER OF FALLS SINCE LAST REVIEW: ____ WERE THERE ANY INJURIES: ____ YES ____ NO IF YES, WHAT WERE THEY?

39. SINCE THE LAST REVIEW, HAVE THERE BEEN ANY UNSUAL OCCURANCES IN RECIPIENT'S LIFE? YES ____ NO ____
IF YES PLEASE DESCRIBE:

40. SIGNATURE OF PERSON COMPLETING THIS SECTION 41. TITLE 42. DATE

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION
0

Specify where copies of this form are maintained:

Division of Mental Health and Developmental Disabilities

HOME AND COMMUNITY-BASED WAIVER SERVICES
CLIENT CHOICE OF SERVICES CCMC Waiver

Name	Care Coordinator
Address	Care Coordination Agency
Social Security/Medicaid #	Requested Services Start Date

I have gone through the CCMC Eligibility Process with DMHDD and have been given a Care Coordination assignment number (CCAN) to be assessed for Medicaid Waiver eligibility. A comprehensive care coordination planning team, which I or my representative participated in, has completed a Plan of Care that has been presented to me: (*please check each box as you read and understand the statement*.)

I understand that:

❑ This is an application to find out if Medicaid will pay the cost of my long-term care services.

❑ If I am found eligible, and if services are available to me in my community, I may choose to receive care in

1. An nursing home; OR
2. Receive Medicaid Waiver Home and Community Based Services in my home and in my community as written in my Plan of Care; OR
3. Receive Community Services only (including the services I may be receiving now); OR
4. I may choose to have no Medicaid or Community services at all.

❑ If I choose to receive institutional care in a nursing home, the care coordinator named above will help me select a facility to meet my needs.

❑ If I choose to request the home and community-based services described in the attached Plan of Care, the DMHDD staff will review my case to see if I meet the Level of Care eligibility requirements and they will evaluate the services requested to be sure they are appropriate and are available in my community.

❑ If I choose to have no Medicaid services but do want to have Community services that are available where I live, my Care Coordinator, DMHDD Grantee Agency or DMHDD staff will assist me to find participating agencies.

❑ I have the right to consult with whomever I choose before making this decision, including friends, relatives and advocacy organizations, and that I may authorize any of these people to contact the care coordinator or DMHDD Staff to provide information in helping make this decision.

❑ If I choose home and community-based services but am denied because services are not available, I may still be eligible for care in a nursing home.

❑ I will receive written notice and an explanation of my appeal rights as presented in 7 AAC 49, if for any reason, I am

5. Found to be ineligible for Medicaid, or
6. Found to be ineligible for Medicaid Waivers, or
7. Denied my choice of services or service providers, or
8. Denied my choice between HCB or Institutional Care.

❑ I wish to receive the services described in the attached Plan of Care rather than in an institutional facility. ❑ I do not wish to receive the services described in the attached Plan of Care, and request care in an nursing home. ❑ I do not wish to receive the services described in the attached Plan of Care request but do wish to receive services available through DMHDD community programs rather than care in an institutional facility. ❑ I do not wish to receive the services described in the attached Plan of Care. If I change my mind I will contact the care coordinator or DMHDD to request services.

Client's Signature	Date
OR Legal Representative's Signature (Relationship)	Date

Division of Mental Health and Developmental Disabilities
Waiver Program
Notices of Action, Appeals and Hearings

Introduction

Alaska's Administrative Code (7 AAC 49) provides applicants for, and recipients of Medicaid waiver services, the right to:

1) Notice of adverse actions
2) An appeal of such adverse actions
3) A fair hearing

Specifically, 7 AAC 49 states that an opportunity for a hearing must be granted to any client whose request for an application is denied, whose claim to Medicaid services is denied or not acted upon with reasonable promptness, or whose benefits the division plans to modify or terminate.

Clients in process under the Waiver program, managed by the Division of Mental Health and Developmental Disabilities (DMHDD), may experience lengthy processing time, denied level of care that results in denial of Medicaid waiver services, or have services or providers changed, modified or denied. They may also receive denials of Medicaid benefits from the Division of Public Assistance (DPA).

Notice of Adverse Action

DMHDD and DPA have the responsibility to provide clients with timely written notice of intent to take action denying, suspending, reducing or terminating assistance. Such notices must include the basis (statute, regulation, and policy) for such action and notify the client of his/her right to a hearing. Care coordinators are sent copies of such notices.

Care Coordinators as Client Advocates

Care coordinators have a responsibility to serve as client advocates. In the event of a grievance, care coordinators are expected to offer assistance to the client throughout the process and/or to refer the client to appropriate sources of assistance.

The Formal Hearing Request

A request for a hearing may be made orally or in writing by the client, or by the client's representative, within 30 days of receiving a notice from DMHDD or DPA of intended action. The request can be made to any employee of the Division of Mental Health and Developmental Disabilities or to the client's eligibility technician or other staff in the Division of Public Assistance.

Requests for hearings are forwarded to the Division of Medical Assistance (DMA) which has the responsibility for conducting fair hearings involving Medicaid issues. No later than 15 days after the receipt of a request, DMA will schedule a hearing and notify the client in writing of the time, date and place of the hearing.

Client Assistance
Upon oral or written request from the client, DMA will provide assistance to the client in obtaining representation, preparing his/her case, and gathering witnesses and/or documents to be used in presenting his/her claim. The client may choose to represent him/herself or have a representative such as a care coordinator, guardian, attorney, friend or family member may be the client representative at the fair hearing.

Fair Hearing
DMA's hearing officer will preside over the proceeding, listen to statements, review records/documents and render a decision no later than 90 days after the receipt by the division of the request for a hearing. The hearing officer will provide the decision to the client in writing. Information will be included to inform the client of his/her right to appeal the hearing officer's decision to the Director, Division of Medical Assistance.

DMA Director's Review
The client must submit his/her appeal of the decision of the DMA hearing officer to the DMA Director within 15 days of receipt of the hearing officer's written decision. Appeal to the DMA Director constitutes the final administrative action available to a client.

The DMA Director must review the record of the hearing, the hearing officer's decision, and applicable laws, regulations, and policies, and render a written decision. This review must be completed no later than 10 days after receiving a client's request for review. The DMA Directors' decision will be sent to the client in writing and will include a statement of the client's right to judicial review.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

_____ Social Worker (qualifications attached to this Appendix)

__X__ Case Manager

__X__ Other (specify): Qualified DMHDD Regional Program or DMHDD Central Office staff meeting care coordination standards may elect to perform this service under 7 AAC 43.1040 (f)

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

__X__ By case managers

__X__ By the agency specified in Appendix A

_____ By consumers

_____ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

__X__ Every 12 months

_____ Other (specify):

_____

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Following the information gathering phase, which has included the consumer, family, and multidisciplinary team, the qualified Care Coordinator or qualified DMHDD staff care coordinator prepares a plan of care. Qualified DMHDD Program Administrator approves the plan of care by signing the plan of care.

Final approval of waiver applicants is based on the following:
1) the client meets eligibility requirements for HCB Waiver Medicaid;
2) the client meets the level of care requirement as determined by DSS;
3) there is space available on the CCMC waiver;
4) there are qualified HCB Waiver Services Providers with the capacity to meet approved service levels on the consumer's POC and also meet health and safety requirements;
5) the level of care determination and the plan of care have been adequately documented and approved.

Final approval of waiver applicants does not occur until all determinations have been completed and are approved by the DMHDD. The Division of Medical Assistance retains the final review and approval authority for all aspects of the HCB Waivers.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Alaska CCMC Plan of Care

Section I Personal Information:	***Plan of Care Start Date:*** ***Plan of Care End Date:***

Last Name:	First Name:	Legal Name if Different:

Male ☐	Female ☐	Married ☐	Single ☐
Hair Color:	Eye Color:	Height:	Weight:

Race: Client's Primary Language:	Primary means of communication:

DOB:	Medicaid #: 06	Is this a Transition Plan?
SSN:	CCAN Number:	Yes ☐ No ☐

Other Insurance of Health Care Service No ☐	Yes ☐ If yes name/number:

Physical Address:		
City:	State:	Zip:
Client Phone Number:	Email Address:	
Mailing Address:		
City:	State:	Zip:

School Name:			Phone Number:
School Address:	City:	State:	Zip:
Contact Name:			
Place of Employment:			Phone Number:
Contact Name:			
Employment Address:	City:	State:	Zip:

Legal Representative:	Role/Relationship:
Mailing Address:	
City: State:	Zip:
Work Phone Number:	Pager or Cell Phone Number:
Home Phone Number:	Email Address:

Emergency Contact:	Role/Relationship:
Work Phone Number:	Home Phone Number:
Email Address:	
Address:	
City: State:	Zip:

DMHDD Agency Providing Services:	Agency Contact:
Address:	Phone Number:
City: State:	Zip:
Email Address:	

HCB Wavier Care Coordination Agency:	CMG#
Care Coordinator:	CM#
Address:	
City: State:	Zip:
Phone Number:	Cell Phone Number:
Pager Number:	Email Address:

Section II Diagnosis:

List primary diagnosis (qualifying diagnosis for CCMC Waiver) :

Secondary diagnosis (all other diagnosis):

Adaptive Equipment: List adaptive equipment that is currently in use, and that which is needed now and/or within the next year.

Medications: List Medications taken, means of administering each medication and the level of assistance needed to help consumer take medications:

List of Medications	Dosage	Means of administering	Reasons for taking	Level of assistance needed

A personal shapshot: On a separate sheet of paper, please write a summary of the consumer including a typical day, favorite activities, strengths, religious affiliations, family relationships, sports, desires, etc. These comments will assist in service selections and goals.

Section IV: Service Summary

The completed Plan of Care should clearly and concisely communicate the strengths, needs, desires and plans for a CCMC Waiver consumer in such a manner that a new provider could pick up the document and use it as a working tool to provide services. The Plan of Care is meant to be inclusive, rather than just addressing the qualifying diagnoses for the HCB Waiver.

The Goals and *Objectives in the POC determine how identified functional needs will be addressed through a combination of HCB Waiver and Non-HCB Waiver community services and providers to prevent the consumer's institutionalization in a nursing facility.*

Not all needs identified in the evaluation process have to be addressed with goals and objectives, just as there may be other goals that are very important to the consumer that are met through non-HCB Waiver programs. However, all functional deficits must be addressed to assure health and safety as well as promoting maximum independence of the consumer.

List as many long-term goals and short-term objectives as necessary to link the Plan of Care to service needs identified in the Level of Care (LOC) determination.

All goals and objectives must be measurable. ***Use additional pages as necessary***.

I. Long-term Goal (1-5 years) :
Alaska LTC Assessment need addressed with this goal:
Short term objective(s) related to this long term goal:
Service to be provided that will address this goal:
Frequency and duration of service: Position that does teaching/training:
How objective will be measured:

2. Long-term Goal (1-5 years) :
Alaska LTC Assessment need addressed with this goal:
Short term objective(s) related to this long term goal:
Service to be provided that will address this goal:
Frequency and duration of service: Position that does teaching/training:
How objective will be measured:

Write as many Goals and Objective as are necessary. Use additional paper as needed.

Section V Summary of Services: *List services to assure that functional deficits identified in the LOC are addressed as required under the HCB Waiver State Plan. Include all types of services this consumer requires to work towards goals. (Include grantee services, profit and not for profit community programs, HCB Waiver services, family supports and any other individuals or programs, whether service is donated or paid for as a waiver service):*

Example:

Provider of service	***Type of service used***	***Description of services to be provided that will meet consumer needs & goals***	***How often***	***Duration (how long)***
Just like home, Inc.	HCB Provider of Day Hab Services	Work with client to shop for food and prepare meals	2 hours a day, 5 x a week.	52 weeks
Aunt Millie	Transportation to MD	Gives client a ride to MD	1 round trip	2 x a month

Provider of service	***Type of service used***	***Description of services to be provided will meet consumer needs & goals***	***How often***	***Duration***
HCB Waiver Services				
Regular Medicaid Health Care Services				
DMHDD Grantee Agency Services				
Community programs				
Family supports				
Other Services				

The following individuals participated in this care planning team

Name	Relationship	Agency	Name	Relationship	Agency
Name	Relationship	Agency	Name	Relationship	Agency
Name	Relationship	Agency	Name	Relationship	Agency

Section VI Consumer Choice :
Please read, and if in agreement read, initial each statement and/or check the box :

This Individualized Plan of Care has been carefully planned and coordinated with the active involvement of the person served. The plan is individually tailored, establishes goals and objectives that incorporate the unique needs and preferences of the person served. Necessary personnel and the person served should be involved in the plan's development and the evaluation of its continuing appropriateness.

It has been explained that the intended purpose of this plan is to help me/my child to maximize my/their independence and lead a productive life. I, or any member of my team, may request another meeting at any time during the next 12 months to make major changes to this plan.

Finally, it has been explained that each member of my program planning team will receive a copy of the final Plan of Care. Unless otherwise stated, I am in agreement with this Plan of Care.

- ☐ I have participated in the planning of my own care and agree with my plan of care.
- ☐ I have the right to self-determination, including participation in developing my own plan of care.
- ☐ I have the right to privacy and confidentiality.
- ☐ I have the right to be given a fair and comprehensive assessment of my health and functional, psychosocial and cognitive ability.
- ☐ I have the right to access health and social services offered under Alaska's Medicaid State Plan though my options may be limited based on the geographic location of the community in which I live and enrolled service providers.
- ☐ I have the right to know the cost of service before receiving care.
- ☐ I have the right to be notified in writing of any change in services, termination of services, or discharge from waiver services, including the right to appeal any decision.(See following page of this document)
- ☐ I have the right to refuse any portion of the plan of care.
- ☐ I have the right to change service providers, including my care coordinator, at any time.
- ☐ I have the right to withdraw from the waiver application process at any time.
- ☐ In the event I feel my rights have been violated or I have been treated improperly I have been given a phone number to call and understand I have the right to a grievance procedure.
- ☐ All of the options available in my community of choice have been fully explained to me.

I choose to receive:

- ☐ Waiver and community services, or
- ☐ Community services only, or
- ☐ Services in an institution (ICF/MR), or
- ☐ No state coordinated services at all.

Consumer Signature	Date	Parent or Legal Representative	Date
Care Coordinator Signature	Date	DD Grantee Agency Representative	Date
HCB Agency Representative	Date	HCB Agency Representative	Date
HCB Agency Representative	Date	HCB Agency Representative	Date

I have reviewed this Plan of Care and approve the services as noted.

DMHDD Regional Program Specialist QMRP	Date	DMHDD Administrator/ QMRP	Date

Division of Mental Health and Developmental Disabilities
Waiver Program Notices of Action, Appeals and Hearings

Introduction
Alaska's Administrative Code (7 AAC 49) provides applicants for, and recipients of Medicaid waiver services, the right to:

1) Notice of adverse actions
2) An appeal of such adverse actions
3) A fair hearing

Specifically, 7 AAC 49 states that an opportunity for a hearing must be granted to any client whose request for an application is denied, whose claim to Medicaid services is denied or not acted upon with reasonable promptness, or whose benefits the division plans to modify or terminate.

Clients in process under the Waiver program, managed by the Division of Mental Health and Developmental Disabilities (DMHDD), may experience lengthy processing time, denied level of care that results in denial of Medicaid waiver services, or have services or providers changed, modified or denied. They may also receive denials of Medicaid benefits from the Division of Public Assistance (DPA).

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DMHDD and DPA have the responsibility to provide clients with timely written notice of intent to take action denying, suspending, reducing or terminating assistance. Such notices must include the basis (statute, regulation, and policy) for such action and notify the client of his/her right to a hearing. Care coordinators are sent copies of such notices.

Care Coordinators as Client Advocates
Care coordinators have a responsibility to serve as client advocates. In the event of a grievance, care coordinators are expected to offer assistance to the client throughout the process and/or to refer the client to appropriate sources of assistance.

The Formal Hearing Request
A request for a hearing may be made orally or in writing by the client, or by the client's representative, within 30 days of receiving a notice from DMHDD or DPA of intended action. The request can be made to any employee of the Division of Mental Health and Developmental Disabilities or to the client's eligibility technician or other staff in the Division of Public Assistance.Requests for hearings are forwarded to the Division of Medical Assistance (DMA) which has the responsibility for conducting fair hearings involving Medicaid issues. No later than 15 days after the receipt of a request, DMA will schedule a hearing and notify the client in writing of the time, date and place of the hearing.

Client Assistance
Upon oral or written request from the client, DMA will provide assistance to the client in obtaining representation, preparing his/her case, and gathering witnesses and/or documents to be used in presenting his/her claim. The client may choose to represent him/herself or have a representative such as a care coordinator, guardian, attorney, friend or family member may be the client representative at the fair hearing.

Fair Hearing
DMA's hearing officer will preside over the proceeding, listen to statements, review records/documents and render a decision no later than 90 days after the receipt by the division of the request for a hearing. The hearing officer will provide the decision to the client in writing. Information will be included to inform the client of his/her right to appeal the hearing officer's decision to the Director, Division of Medical Assistance.

DMA Director's Review
The client must submit his/her appeal of the decision of the DMA hearing officer to the DMA Director within 15 days of receipt of the hearing officer's written decision. Appeal to the DMA Director constitutes the final administrative action available to a client. The DMA Director must review the record of the hearing, the hearing officer's decision, and applicable laws, regulations, and policies, and render a written decision. This review must be completed no later than 10 days after receiving a client's request for review. The DMA Directors' decision will be sent to the client in writing and will include a statement of the client's right to judicial review.

CCMC Waiver CLIENT CHOICE OF SERVICES

Name	Care Coordinator
Address	Care Coordination Agency
Social Security/Medicaid #	Requested Services Start Date

This form is to be filled out after the Comprehensive Planning team has completed the Plan of Care. Having a completed or approved Plan of Care does not guarantee eligibility for Medicaid Services. HCB Waiver applicants must continue to meet Division of Public Assistance annual eligibility requirements. In addition, certified and enrolled providers must be available to provide services before services can be authorized

I have gone through the Developmental Disabilities Eligibility Process with DMHDD and have been given a Care Coordination assignment number (CCAN) to be assessed for Medicaid Waiver eligibility. A Comprehensive Planning Team, which I or my representative participated in, has completed a Plan of Care that has been presented to me. *(Please check each box as you read and understand the statement*.)

I understand that:

❑ This is an application to find out if Medicaid will pay the cost of my long-term care services.

❑ If I am found eligible, and if services are available to me in my community, I may choose to receive care in

1. A nursing facility; OR
2. Receive Medicaid Waiver Home and Community Based Services in my home and in my community as written in my Plan of Care; OR
3. Receive Community Services only (including the services I may be receiving now); OR
4. I may choose to have no Medicaid or Community services at all.

❑ If I choose to receive institutional care in a nursing facility, the care coordinator named above will help me select a facility to meet my needs.

❑ If I choose to request the home and community-based services described in the attached Plan of Care, the DMHDD staff will review my case to see if I meet the Level of Care eligibility requirements and they will evaluate the services requested to be sure they are appropriate and are available in my community.

❑ If I choose to have no Medicaid HCB Waiver Services but do want to have Community services that are available where I live, my Care Coordinator, DMHDD Grantee Agency or DMHDD staff will assist me to find participating agencies.

❑ I have the right to consult with whomever I choose before making this decision, including friends, relatives and advocacy organizations, and that I may authorize any of these people to contact the care coordinator or DMHDD Staff to provide information in helping make this decision.

❑ If I choose home and community-based services but am denied because services are not available, I may still be eligible for care in a nursing facility.

❑ I will receive written notice and an explanation of my appeal rights as presented in 7 AAC 49, if for any reason, I am

1. Found to be ineligible for Medicaid, or
2. Found to be ineligible for Medicaid Waivers, or
3. Denied my choice of services or service providers, or
4. Denied my choice between HCB or Institutional Care.

❑ I wish to receive the services described in the attached Plan of Care rather than in an institutional facility. I will receive a copy of my Plan of Care and a cost sheet with approved services after it has been approved by DMHDD. This will be given to me by my Care Coordinator.

❑ I do not wish to receive the services described in the attached Plan of Care, and request care in a nursing facility.

❑ I do not wish to receive the services described in the attached Plan of Care request but do wish to access DMHDD CORE services, which are limited to $3450 annually. If this is my choice I will receive a list of services available in my community from my Care Coordinator.

❑ I do not wish to receive any of the services described in the attached Plan of Care.

If I change my mind I will contact the care coordinator or DMHDD to request services.

Client's Signature	Date
OR Legal Representative's Signature (Relationship)	Date

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

__X__ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

_____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

_____ Other (Describe in detail):

b. BILLING PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

a. When the individual was eligible for Medicaid waiver payment on the date of service;

b. When the service was included in the approved plan of care;

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

__X__ Yes

_____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

__X__ All claims are processed through an approved MMIS.

_____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

_____ The Medicaid agency will make payments directly to providers of waiver services.

____X____ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

_____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: Nursing Facility

YEAR	PEOPLE	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
YR1	**157**	**$ 46,075**	**$ 20,956**	**$ 80,866**	**$ 24,136**
YR2	**174**	**$ 46,892**	**$ 21,417**	**$ 82,645**	**$ 24,668**
YR3	**192**	**$ 47,675**	**$ 21,888**	**$ 84,463**	**$ 25,210**
YR4	**209**	**$ 48,461**	**$ 22,370**	**$ 86,321**	**$ 25,765**
FY5	**226**	**$ 49,357**	**$ 22,862**	**$ 88,220**	**$ 26,332**

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	157
2	174
3	192
4	209
5	226

EXPLANATION OF FACTOR C:

Check one:

__X__ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

____ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit that is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: Nursing Facility

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages.

Factor D is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Residential habilitation, day habilitation, habilitation intensive active treatment/therapies, care coordination, meals, supported employment and chore services may be given at assisted living homes or residential supported living facilities. The licensed assisted living or licensed foster homes providers document billing recipient, family or other source for the cost of basic board and room which is not reimbursable by Medicaid.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

When developing payment rates for above services, room and board components are excluded. Client room and board costs are specifically noted on cost sheet, and are the responsibility of the qualified provider to collect.
Meals reimbursed through the HCB Waivers shall not constitute a full day's regimen and will be limited to 1 or 2 meals per day.

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Residential habilitation, day habilitation, habilitation intensive active treatment/therapies, care coordination, meals.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

When developing payment rates for above services, room and board components are excluded. Client room and board costs are specifically noted on cost sheet, and are the responsibility of the qualified provider to collect.
Meals reimbursed through the HCB Waivers shall not constitute a full day's regimen and will be limited to 1 or 2 meals per day.

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

__X__ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

_____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: Nursing Facility

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: Nursing Facility

Factor D' is computed as follows (check one):

_____Based on HCFA Form 2082 (relevant pages attached).

_____Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.

_____Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X_____Other (specify):

Factor D’ is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

APPENDIX G-6

FACTOR G

LOC: Nursing Facility

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for NF care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____ Based on trends shown by HCFA Form 372 for prior years of waiver #0263.90, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

___X___ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

The actual cost of care for individuals age 0-21 years who did not receive CCMC waiver services and were hospitalized for 30 days or more in FY00.

_____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

_____ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: Nursing Facility

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted."

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: Nursing Facility

Factor G' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 for prior years of waiver # 0263.90 , which serves a similar target population.

Factor G' is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

_____

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: Nursing Facility

Year I					
Factor D	$	46,075	**Factor G**	$	80,866
Factor D'	$	20,956	=**Factor G'**	$	24,136
Total D value	$	67,031	**Total G value**	$	105,002
Year 2					
Factor D	$	46,892	**Factor G**	$	82,645
Factor D'	$	21,417	=**Factor G'**	$	24,668
Total D value	$	68,309	**<Total G value**	$	107,313
Year 3					
Factor D	$	47,675	**Factor G**	$	84,463
Factor D'	$	21,888	=**Factor G'**	$	25,210
Total D value	$	69,563	**<Total G value**	$	109,673
Year 4					
Factor D	$	48,461	**Factor G**	$	86,321
Factor D'	$	22,370	=**Factor G'**	$	25,765
Total D value	$	70,831	**<Total G value**	$	112,086
Year 5					
Factor D	$	49,357	**Factor G**	$	88,220
Factor D'	$	22,862	=**Factor G'**	$	26,332
Total D value	$	72,219	**<Total G value**	$	114,552